# The Delaware Health Care Commission Meeting

May 3, 2018 - 9 a.m. to 11 a.m.

Meeting Attendance

**Commission Members Present:** Dr. Nancy Fan (Chair); Secretary Kara Odom Walker (DHSS); Theodore W. Becker (Mayor of Lewes); Trinidad Navarro (DOI); Dennis Rochford (Maritime Exchange for DE River & Bay); Dr. Edmondo Robinson (Christiana Care Health System); Dr. Jan Lee (DHIN); Richard Heffron (DE State Chamber of Commerce) and Rick Geisenberger (DOF)
**Commission Members Absent:** Dr. Kathleen Matt (University of Delaware); Josette Manning, Esq. (DSCYF)

**Facilitator:** Dr. Nancy Fan (Chair)

**Health Care Commission Staff:** Ann Kempski, Executive Director
Keanna Faison, Director of Policy & Planning
La Ronda Moore, Executive Program Assistant

**Call to Order**

Chair Dr. Nancy Fan called the meeting to order at approximately 9:00 a.m. Dr. Fan introduced a two new Health Care Commission staff members,

**Meeting Minutes Approval – May 3, 2018**

Dr. Nancy Fan, commission chair, requested the commissioners to briefly review the April 5th meeting minutes.

Dr. Edmondo Robinson, Secretary Kara Odom Walker, Dr. Jan Lee, Dr. Nancy Fan and Ann Kempski had a discussion regarding the April 5, 2018 meetings on the following topics: the role of the Advisory Group spending and quality sub-committees, the contract with Mercer and their sub-contractors and the Common Scorecard measures.

Dr. Nancy Fan requested a vote to approve the April 5, 2018 meeting minutes assuming that the modifications will be updated as discussed. Dr. Edmondo Robinson motioned to approve the April 5, 2018 meeting minutes pending requested modifications. Ted Becker and Richard Heffron seconded the motion. All were in favor. Motion carried.

*see modifications in section II, and IV of the April 5, 2018 meeting minutes

**Current Health Trends in Delaware – Secretary Kara Odom Walker**

Secretary Walker provided a brief overview and history of the Health Fund Advisory Committee and the work they do in Delaware. Key Highlights from Secretary Walker's presentation include:

- The Health Fund Advisory Committee was developed in 1997. The committee as it currently stands, has recommended to revisit the application process and consider how to accept new programmatic information requests.
- There was a request to add a line item for an innovation fund to incentivize new ideas to address health issues.
- Eight key areas were called out in the committee. The funds from the tobacco settlement were intended to be used for the following (paraphrased):
    1. Expand health care access and insurance
    2. Enhance health care infrastructure
    3. Promote healthy lifestyles
    4. Promote preventive care
    5. Detect and identify lesser-known and costly illnesses
    6. Promote a payment assistance program for prescription drugs
    7. Address those whom are suffering from debilitating chronic illnesses
    8. Cover other expenditures deemed necessary
- The Committee will suggest revisions to the health fund application process and hear presentations from requester of funds.
- The application is posted on the DHSS website here. Public comments will be taken until May 21st on what items should be revisited on the application request.
- Please view Secretary Walker's PowerPoint presentation here.

***Discussion***

Rick Geisenberger commented on slide 71 regarding the graph that represents the Percentage of Female High School Students in Delaware Who Reported Smoking Cigarettes, Drinking Alcohol at Least Once in the Past 30 days, and/or Offered Illicit Drugs in the Past 12 Months.

**Delaware Innovations: Greater Lewes Community Village – Jackie Sullivan**

Ted Becker provided an overview of the Greater Lewes Community Village. Key highlights from his overview include:

- The Greater Lewes Community Village is the result of outgrowth from a Sea Grant that was given in 2010
- About 15% of the individuals who are taking advantage of the services at the Greater Lewes Community Villages are low income
- It is a volunteer-based organization with about 115 volunteers
- Greater Lewes Community Village is the only village in Sussex County
- The organization functions with an 11-member board and a 16-member council
- Annual membership is $500 per individual and $750 per household

Jackie Sullivan presented **Serving Eastern Sussex County: Partnering to Create a Caring Healthy** Community. Key Highlights from Jackie Sullivan's presentation include:

Create a caring healthy community

Introduction by Mayor of Lewes:
Optimal approach is aging in place; large numbers of people aging rapidly in Lewes.
Expanded into Milton, Rehoboth Beach and other zip codes.
15% of people taking advantage of this are low income.
Volunteer based organization; Addressing needs; one of many such organizations in the community of Lewes.
Next 15 to 20 years, 65+ and 85+ individuals, need to address.
The only village in Sussex County. Work with medical practitioners. Team approach, function with 14-member board and 16-member advisory council. $500 membership for individual or $750 for household. Subsidized for those how are financially strapped.

Jackie Sullivan, Executive Director, Greater Lewes Community Village:
Potential model to bring communities and organizations together.
Bring board members, many volunteer, diverse group, together for a common goal.
96 to 98% adults want to live where they made their memories, at home.
We are part of a growing network, 240 villages across the country.
Independent, grassroots organization, starting in 2010; people said we want to stay here and stay healthy and how do we do that?
We serve many areas now.
Volunteer, nonprofit, dedicated to helping older adults live independently as long as possible.

Volunteers get to choose what they want to do.
We collaborate with other organizations such as Beebe, meals on wheels, farmers markets, home health services. Delaware is the 7th oldest state in the nation.
We are in place to help. We have to do this together.
Services provided; primarily transportation, but growing need for respite care, cognitive loss help, other growing needs.
Beebe partnership, received a grant from them; physician practice coordination, wellness centers.

Program to lower readmission rates: One of Villages in Massachusetts developed a program to reduce readmission. Partnering with hospital, case managers, discharge managers, info goes to patient, they plan for next 30 to 60 days to make sure patient gets to the doctor, lab or wherever they have to go. Because most readmission rates are because lack of support.
Statistics from Newton Village, 60-day period, 18 people discharged, became members of the Village and zero readmission rates. This is a program to focus on what is important and what's needed for community.

Sets us apart from other organizations; this is about the whole person; letting them tell their stories, let someone talk. Second set of ears in doc office, listening to take notes to help people have info they need. Fun things too, 90th birthday, volunteers help celebrate. Those moments of joy matter to older adult and to the volunteer. That's what keeps people coming back.
167 members
115 volunteers
How do we grow? Next decisions about that.
Areas served, 19958; 19968; 19971; 19951 Expanding to 19966 and 19930

Affluent? Yes some. But many are not. Older communities, mobile home parks, people who are not aware of the services. Our job is to get out there, messaging.

Steady growth over five years.
Total services YTD 4814 (service requests)
Majority of them for driving: 3798
Over 10000 hours of services in 2017.
Grant from Beebe to help us work with medical facilities and practices.
Extra set of hands to continue to live in their homes—the result can be assisted living and it doesn't have to happen.
We should try to create other villages like this.

The need: we are seeking assistance to support the current population and the grow hot older adults in Sussex County. How you can help us in creating relationships with the most appropriate channels.
Access to information. Maybe Healthy Neighborhoods Committee. How can we get involved in more things?
Keeping people out of the healthcare system. We can help become a model.

Idea here is the aging adult is in charge. You are the boss. Family is involved. But this is about empowering aging people to live their lives as they would like.

UPDATES on ACTIVITIES AND INITIATIVES

David Mangler, Division of professional regulation

What we do: Ensure the protection of public health by delivering services through individual and team initiative, creativity and leadership.
Part of division's umbrella. We receive and process apps for licensure for 54 different professions and occupations; give administration support to boards and commissions and receive and investigate complaints.
Regulatory oversight, typically recognized as the state where the public member's composition is 50%.
400 public meetings and hearings a year.
Have over 270 board and commission members and over 90,000 active licensees.

Totally self-funded through fees we collect.
House the state's prescription monitoring program and activities around that.
We can establish fees to cover costs; define materials for applications; impose monetary fines from inspections; conduct investigations and can contract with licensing vendors.

Recent things we've been doing. Licensure of non-nurse midwives, art therapists; massage and bodywork establishments; Addiction Action Committee; PMP Advisory Committee

Current legislative activities: Board of Clinical Social Work—expands multi-tiered licensure and Board of Occupational Therapy, clean up of current language in statute.

Discussion of nursing compact; those who work in other states can do on license to work here, increases mobility, telemedicine initiatives. Close to 45 states in the compact estimated by next year. Works because uniform practice components/requirements in most states.
Physical Therapy compact; as of April 24, 17 states participating. A draft bill is underway to get the compact introduced into the state of Delaware.

Psychology compact; interstate and includes Canada.

MARKETPLACE UPDATE

Final enrollment down, 11%; as were most states. We have 24,500 consumers who made a plan selection.
Possible reasons for the drop; confusing messages at federal level (uncertainty about ACA); less carriers; broker compensation changed; Medicaid and aging into Medicare.
Consumers selected plans similar to national averages.
Over 80% qualified for cost sharing reductions
Age distribution; very similar to national age distribution. In general, overall pool is aging somewhat; year over year, % of people over 55 years, slight uptick overall. Which impacts the risk pool.
DE consumers facing higher costs; overall premiums are $750 per month; if qualified for tax credit, $122 per month. Our premiums are higher than PA or MD.
4,000 paying full cost of premiums.
Causes for concern: Down to a single carrier in DE; declining year over year enrollment; average DE risk score is 8% higher than national average (this means we have disproportionately higher number of sick people). Maryland's is 3% lower (healthier).
Options: Low probability of a federal fix; do more aggressive outreach; consider using state purchasing through Medicaid program; engage carriers in innovative plan.

SIM UPDATE

Practice transformation; all activities are voluntary, no direct cost to practices; involves coaching.

In year four, behavioral health integration..
Year one: Four vendors worked with 120 practices received coaching—helping practices transform to go to value based care and improve care coordination.

Sustaining this through payment reform to support care coordination.

Medical docs who took advantage of the program: 293; NPs and PAs; 131; Total number clinicians; 424

All health systems were represented.
Now; HMA did site visits, readiness assessments, received assistance, learning collaboratives, content webinars. Finding a way to integrate behavioral health into practice, important in the wellness of a patient.
Successes, identified opportunities for partnerships; set up different platforms; developed workflows; eventually will share knowledge.
Enrolling practices now in behavioral health integration.

Emerging—Primary Care Workgroup: To fulfill offering care for every Delawarean—more access. How can we grow this in Delaware. Collaboration between DHCC, DCHI clinical committee supported by Health Management Associates and DHCC. Want to get white paper by end of 2018. Want to get data to find out where are we, where is access now, where can we go with. Where are our deficiencies? Data to address those. Then assess what's going on throughout the state—stakeholder's roundtable, move to smaller 12 to 15 member group that will create content and then an exec committee will write the report. Hoping to have national experts involved to come talk about what's being done in other states.